**MARICOPA INTEGRATED HEALTH SYSTEM HEALTH PLANS**
**PROTOCOL**

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| SUBJECT: Craniosynostosis (Cranial Head Banding)<br><br>APPLIES TO: MHP ☒ MLTCP ☒<br>MSSP ☐ HEALTHSELECT ☒ | Protocol #: PA P156.02<br>Protocol Pages: 1<br>Attachments: Yes ☐ No ☒<br>Initial Effective Date: June 1999<br>Latest Review Date: May 2002 |

MIHS HEALTH PLANS APPROVALS:

Director, Medical Management:_____ Date:_____

Medical Director:_____ Date:_____

**PURPOSE:** The purpose of this protocol is to state the Prior Authorization Criteria that the Medical Management Department will use as it pertains to Craniosynostosis (Cranial Head Banding).

**PROTOCOL:**

A. The prior-authorization specialist may approve if **all** following are present:
   1. Skull films or CT scan reveals premature fusion are present **and**

   2. No spontaneous improvement after 3 to 10 weeks of frequent position changes and conservative measures.

B. CRS covers post-cranial remodeling surgery.

C. This criteria is a guideline for prior authorization and does not represent a standard of practice of care.

D. This protocol addresses medical coverage issues only and does not review individual benefit coverage issues. In order to issue an authorization number, the procedure must meet medical guidelines and benefit coverage guidelines under the specific plan.

E. If requirements are not met, Medical Director review is required.